The Journey to Value-Based Care and Population Health

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What is the future of value-based care?

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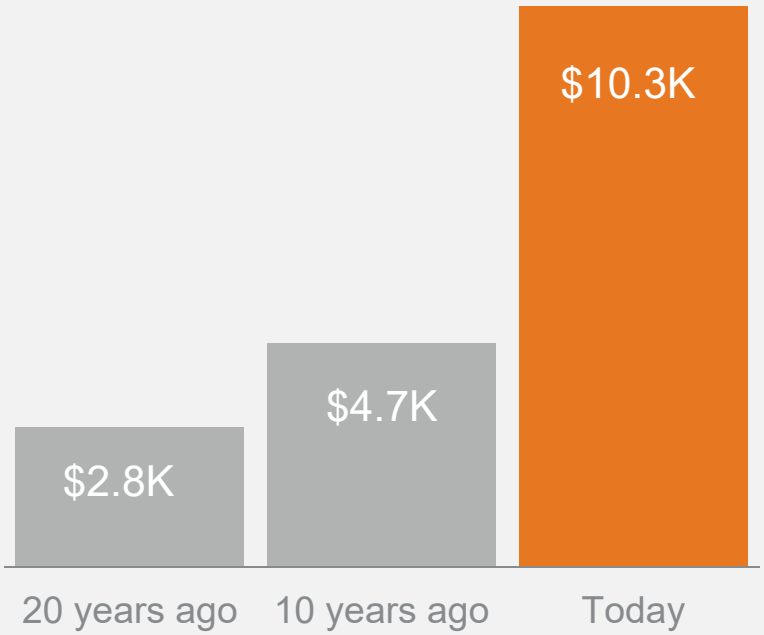
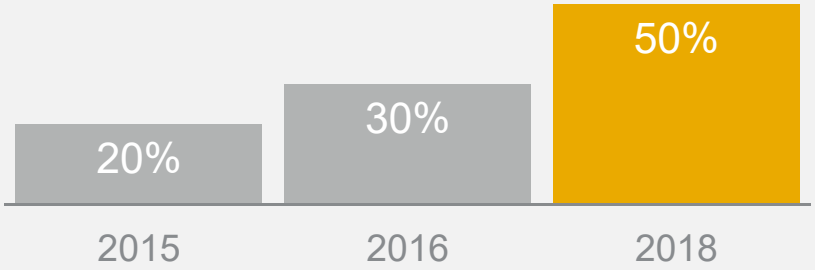
The imperative to lower costs and improve quality will not change

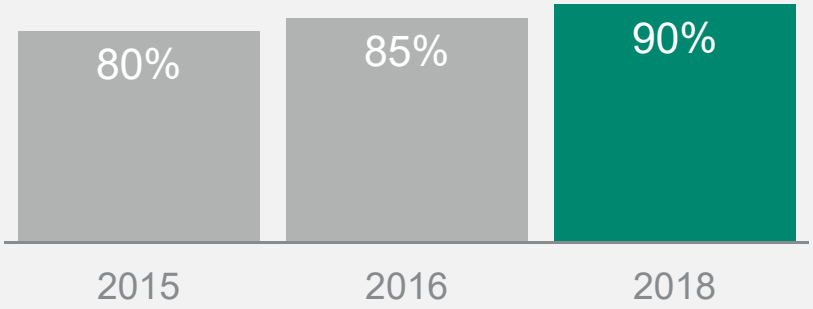
Growing annual health care costs per American



Growing Medicare payments tied to quality



Growing Medicare payments tied to risk



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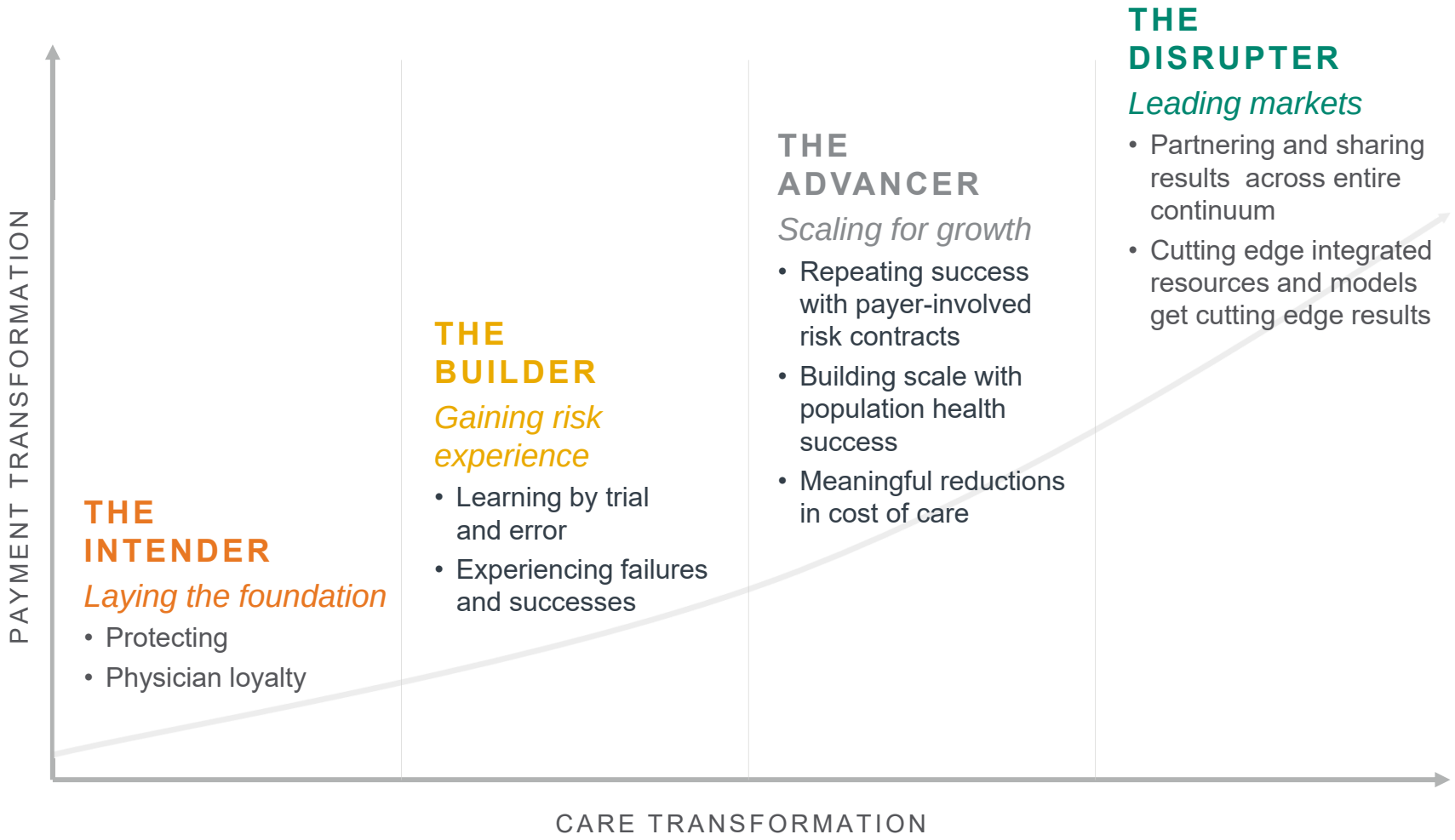
The path and timing to transformation will vary



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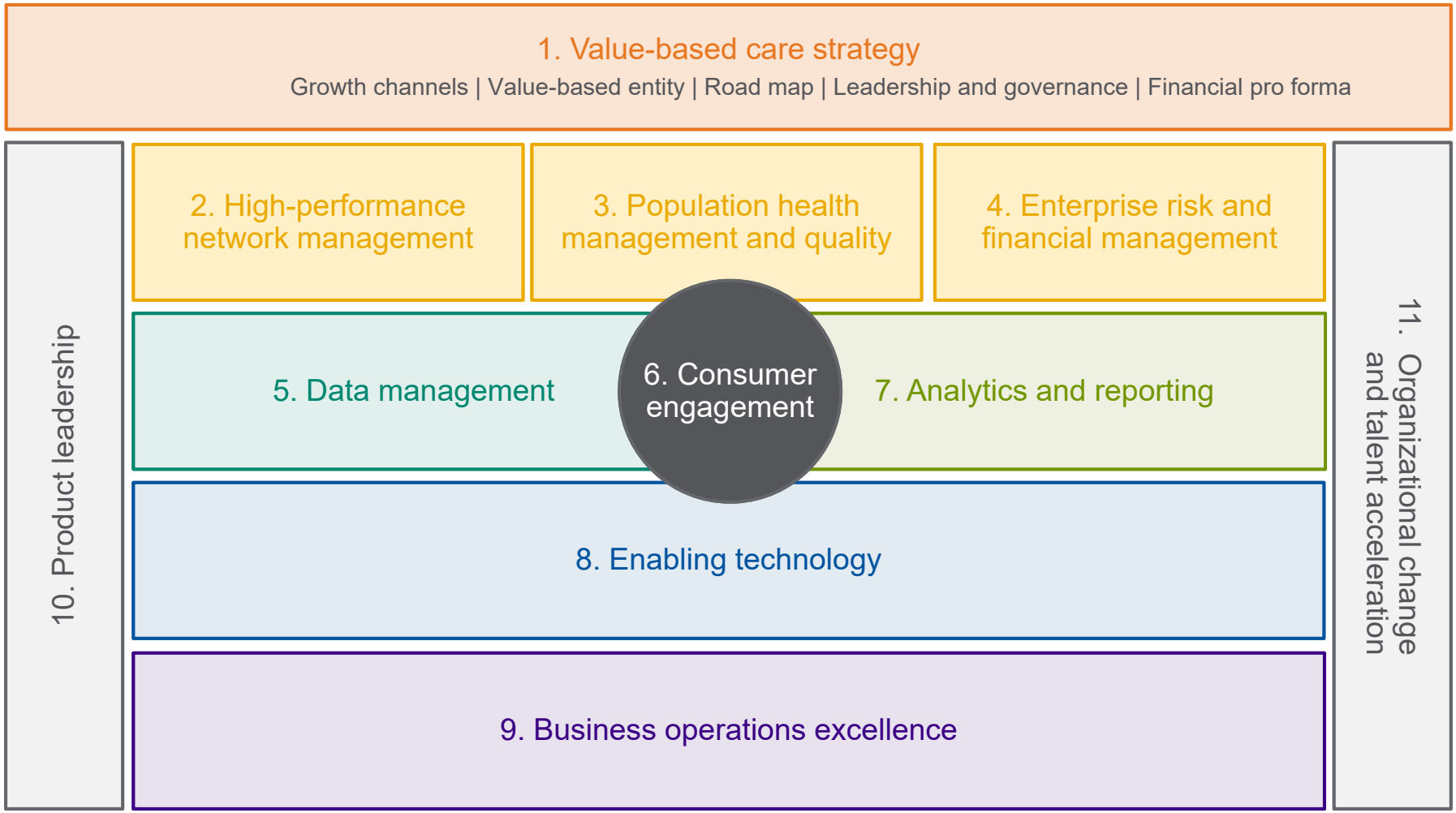
Framework for value-based care



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There are minimum requirements for success

Risk management and growth strategy

Craft a sustainable value-based strategy with a solid financial foundation for profitability and growth.

Network formation and contracting

Develop an aligned physician network; match cross continuum and regional partnerships to market opportunities.

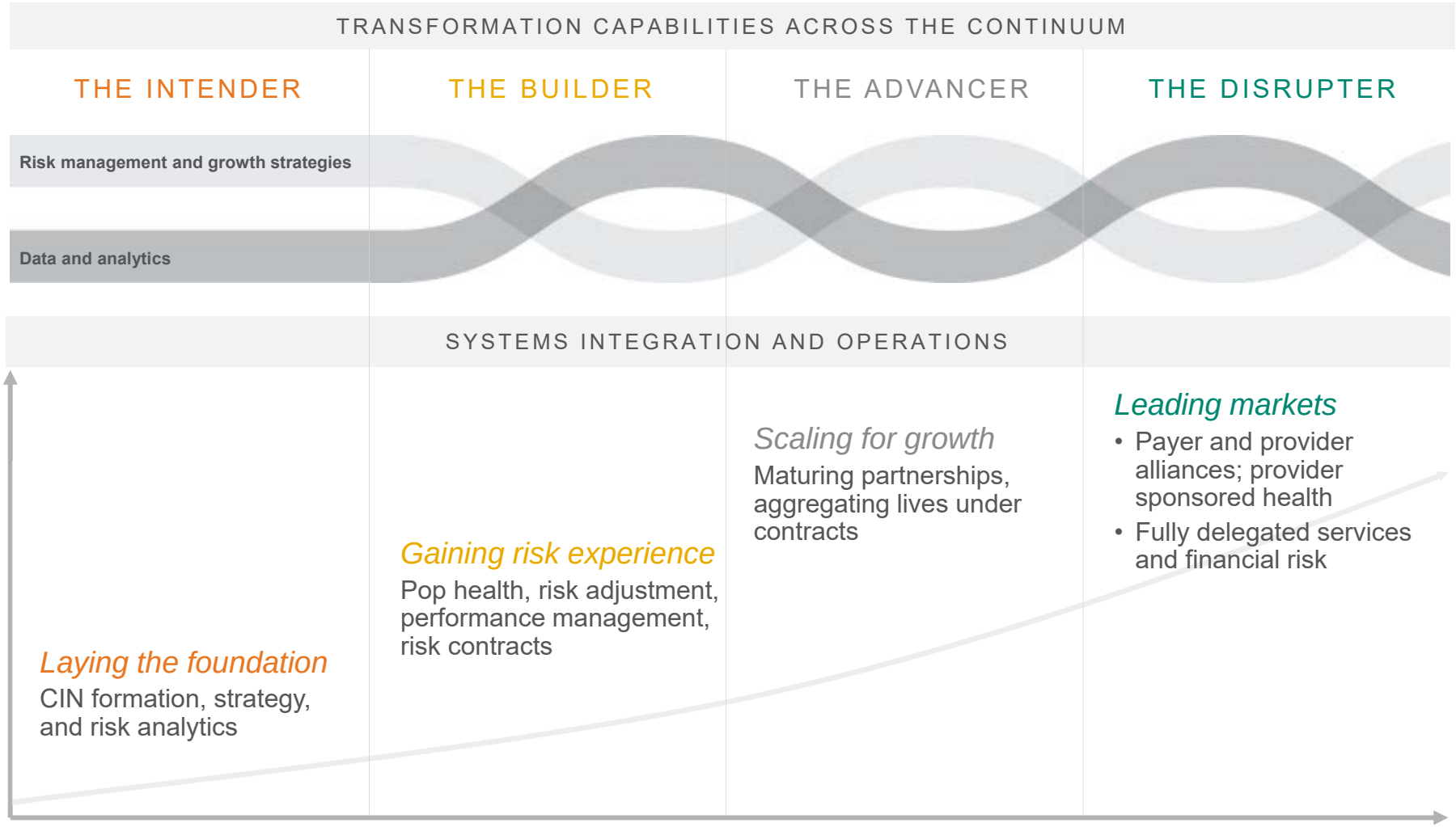
Integrated care delivery

Develop and implement comprehensive, customized, scalable and standardized clinical programs and services.

Integrated partnership

Develop partnerships, centralized infrastructure and local market governance to drive efficient operations. Integrate data and analysis and drive patient health at lower costs.

Leading the right pace with the right capabilities



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Implementing a Data-Driven Population Health Strategy:

The Temple Center for Population Health

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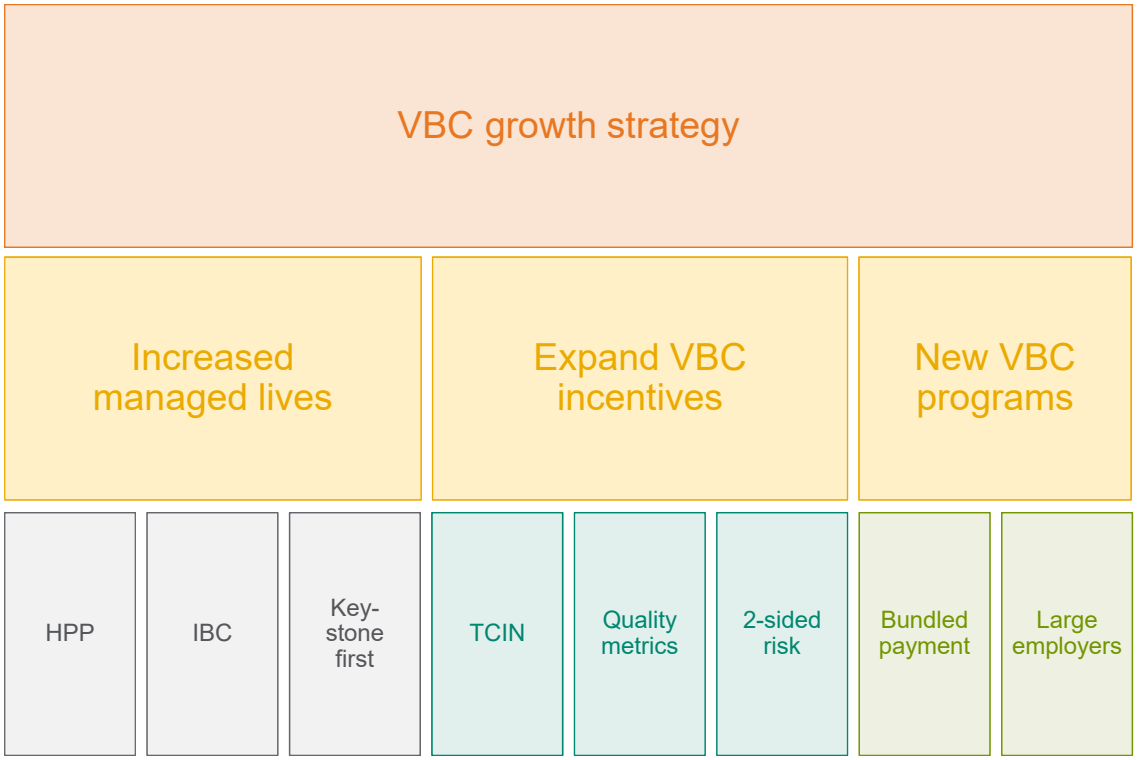
Value-based care strategy

Path to continued growth

Focus on three levers of VBC growth

1. **Grow** number of attributed lives under existing contracts
2. **Expand** scale and scope of incentives under existing or new contracts (clinically integrated networks)
3. **Explore** new VBC arrangements and programs with governmental/ commercial payers and/or large employers



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Temple Center for Population Health
Value-based strategies

Value-based financial models

Risk-based contracts

Quality/cost

Advanced and alternative payment models

Value-based care models

Temple care integrated network

Alternative care locations

Ambulatory transformation and PCMHs

Population health management

Transitions of care

Post-acute narrow network

Social determinants of health

Analytics

Predictive analytics and risk stratification

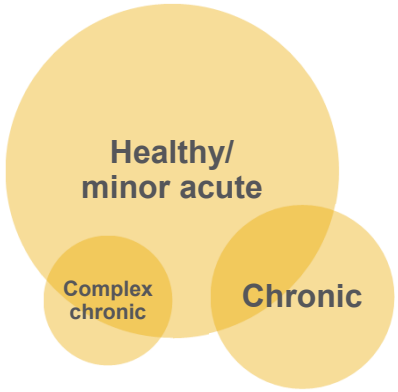
Targeted interventions

Data driven transformation

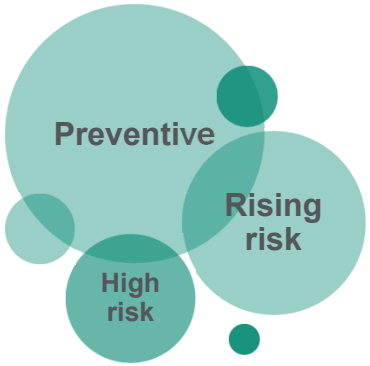
Utilizing analytics to drive action

Using analytics to drive population care management

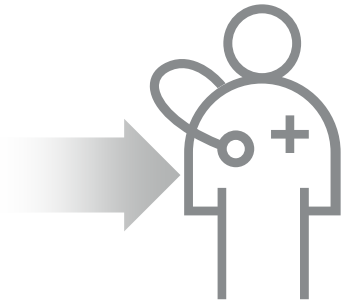
Risk strat attributed population



Segment population



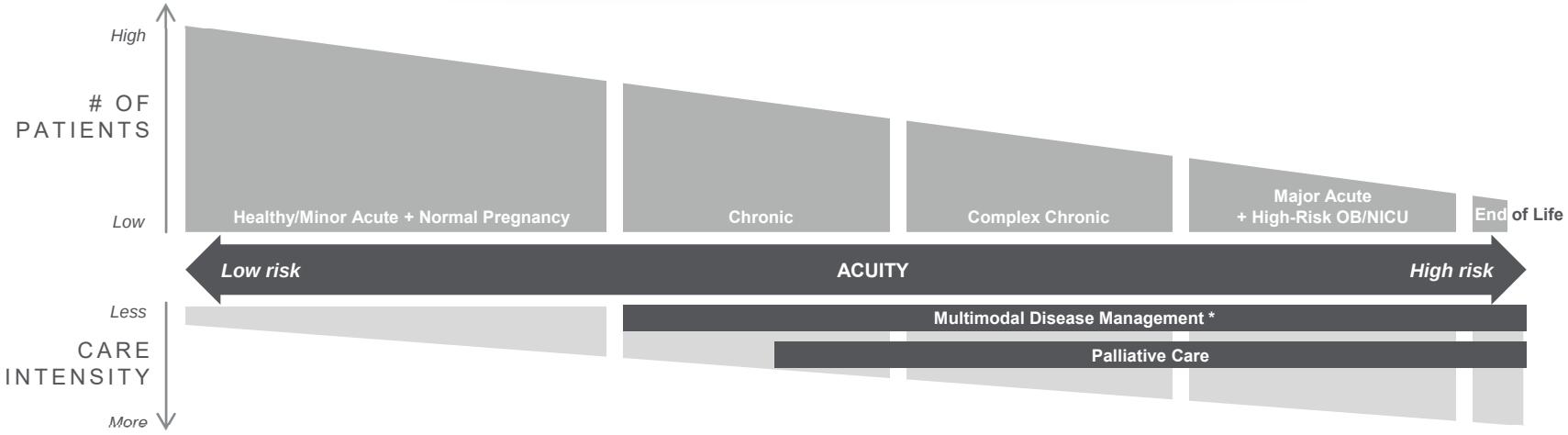
Risk strat population segments



Identified high/rising risk members triaged by care navigator and managed via defined care pathways

Population segmentation

Phase I: Maintain focus on med-high/high risk with emphasis on supplemental income adults with chronic conditions
Phase II: Expand to cover all segments of initial risk contracts
Future state: Expand segmentation to cover all populations in all risk contracts



RESOURCES				
Mid-level provider	Mid-level provider	PCP	Specialist	PCP
	PCP	Specialized clinic	Nurse navigator/ CHW	Specialist
	Nurse navigator/CHW	Specialist	Other allied support	Nurse navigator/CHW
	BH specialists	Nurse navigator/CHW		BH specialists
	Other allied support	BH specialists		Other allied support
		Other allied support		Palliative/ hospice provider

LEGEND: *Multimodal disease management (e.g., education, online engagement, remote monitoring); Other allied support: social worker, pharmacist/medication mgmt, educator, dietitian)
★ Lead provider

Source: 10000 Lives Model of Population Health Care Delivery

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Chronic care analysis (under $200,000 threshold)

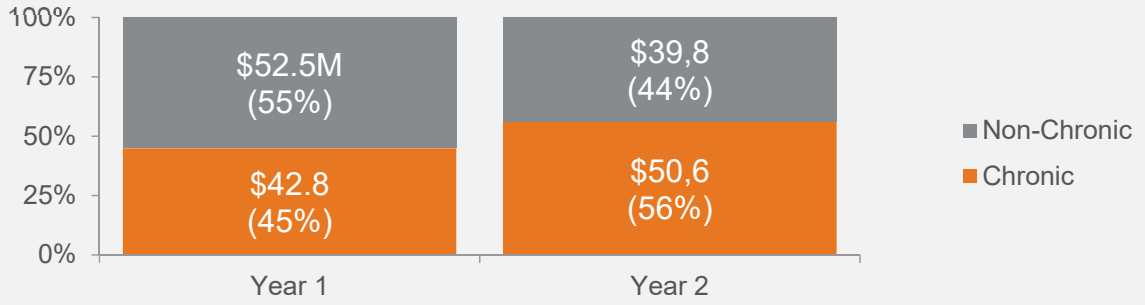
For chronic disease claims under $200,000, **a 18.2% increase in PMPY** occurs year-over-year.

Proportion of total spend allocated to chronic care increased by 11% from Year 1 to Year 2.

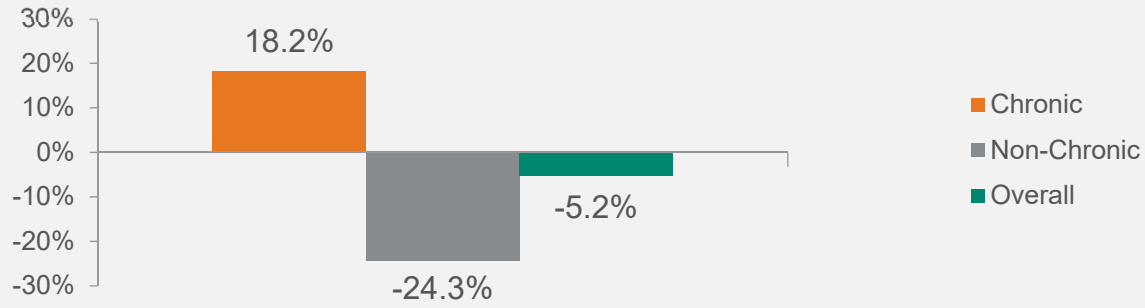
Conclusion

With a significant increase in PMPY for chronic disease claims, the analysis suggests that **chronic disease is a key driver of year-over-year under $200,000 spend trends.**

Under $200,000 spend by chronic and non-chronic



PMPY trend by chronic and non-chronic claims



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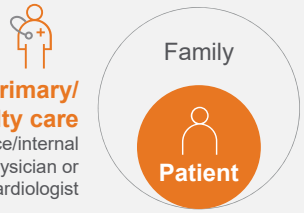
Transformation:
Heart Failure Medical Neighborhood

COMMUNITY

SECONDARY CLINICAL

PRIMARY CLINICAL

Patient-centered medical home



Primary/ specialty care
Family practice/internal medicine physician or cardiologist

Care management
Nurse navigator, community health worker, pharmacist, dietician/ nutritionist

- Patient identification, segmentation, and risk stratification based on CHF prognosis
- Flu and pneumonia vaccination management
- For medium/rising/high risk patients:
  - ED and post-discharge follow-up, including PCP/specialist visit to prevent readmission
  - Disease mgmt and care planning with heart failure program
  - Management of major comorbidities
  - Coordination of community resources to provide additional support
  - Home visit, assessment, and remediation for high-risk patients

Pharmacy/DME
- Medication management and reconciliation (e.g., diuretic, Beta blocker, ACE inhibitor)
- Defibrillator, pacemakers, blood pressure, and pulse oximeter education

Specialty and Palliative Care
- Complex patient management by CHF program/clinic, with co-management by cardiologist, electrophysiologist, and cardiovascular surgeon
- Advanced illness/end-of-life support, including palliative care, hospice, advance directives, POLST/MOLST

Virtual Health
- Remote patient monitoring of biomarkers (e.g., scale, HR and activity monitors, and other wearable devices) connecting home health and lead physician
- Telehealth access to providers

Acute Care
- Episodic acute care at hospitals, emergency departments, and urgent care centers

Post-acute Care
- Cardiac rehabilitation and other post-acute care sites (SNFs, LTACs, and Home Health agencies)
- Home Health connectivity with patient monitoring devices
- Coordination with care management team to manage transitions

Workplace, religious organizations and community locations
- HF risk screening (e.g., 6 for Life)
- Heart failure support groups
- Smoking cessation programs
- Dietary counseling
- Weight management services

Community and public health agencies
- Assistance program enrollment (e.g., SNAP)
- Transportation services
- Permanent and supportive housing assistance programs (e.g., Blueprint Voucher Program, Pathways to Housing PA, etc.)

Expanding VBC contracts with payers

A best practice risk-based contracting strategy ensures that incremental risk/rewards are **proactively incorporated** into contracts and reflect metrics/performance drivers that are **identifiable and addressable** through care management.

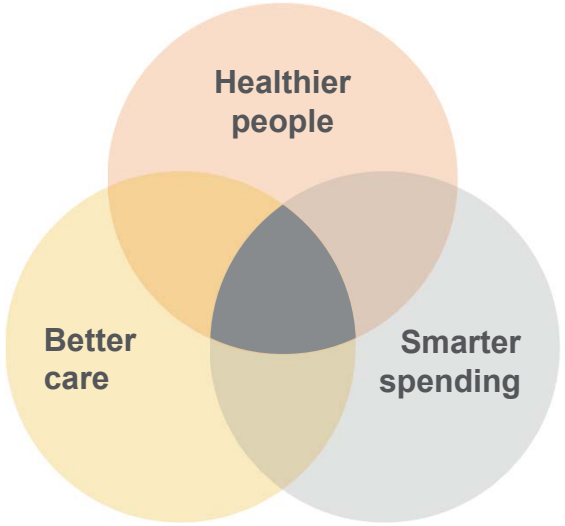
Actuarial driven	• Actuarial analytics/expertise to identify modifiable risk • Service inclusions/exclusions
Process based	• Claims data management and validation • Templates to drive contracting consistency
Strategically aligned	• Alignment with VBC strategy and capabilities • Standardized quality metrics across contracts

Data-driven value

The business model for population health

Value-based population health requires real time, actionable data that drive alternative health care delivery models, population health management methods, incentives and reimbursement models that ultimately improve health outcomes.

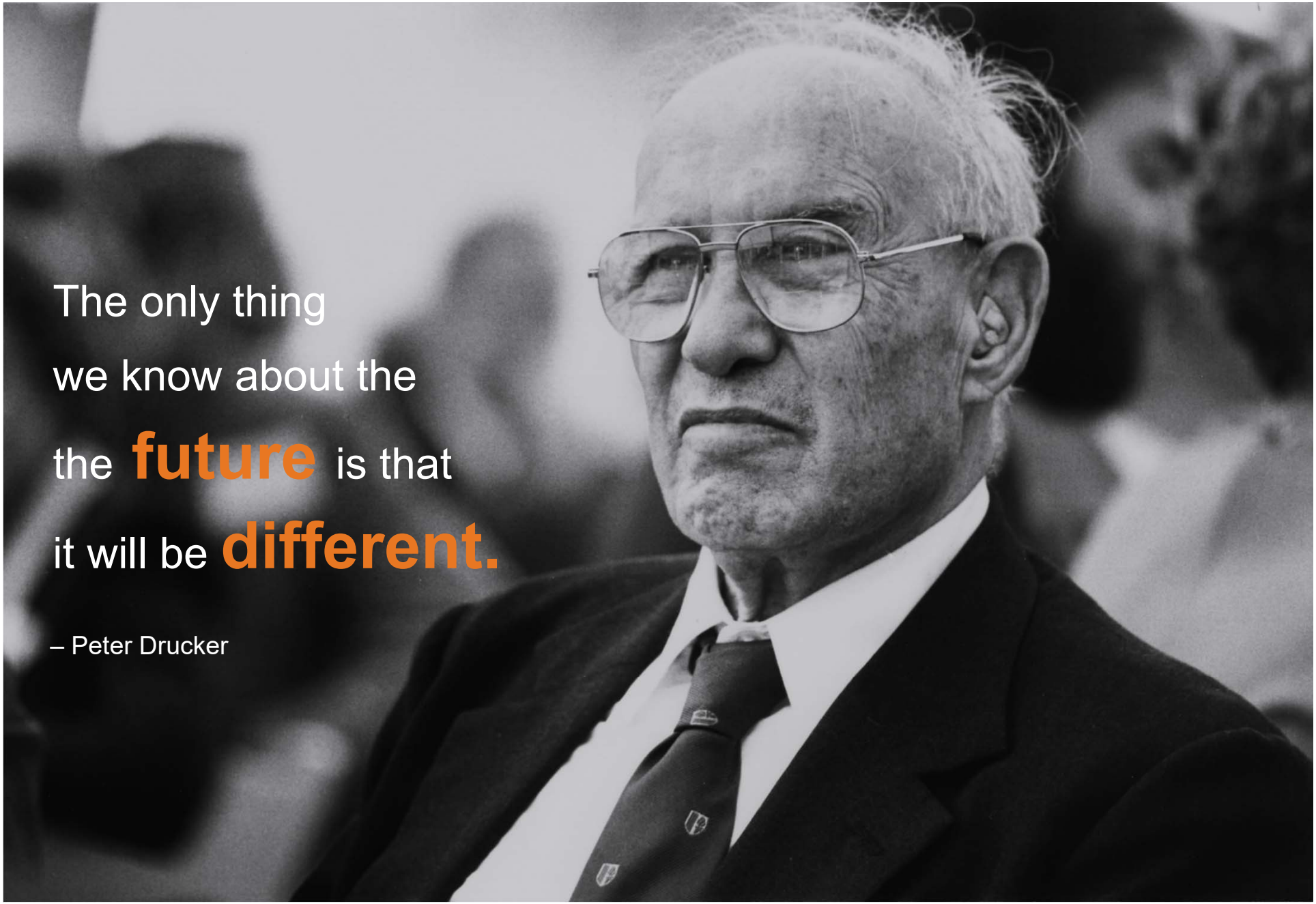
The Triple Aim



VALUE

DATA

Payment models


The only thing
we know about the
the future is that
it will be different.
– Peter Drucker

Thank you

We acknowledge the Population Health teams at the Temple Center for Population Health and Optum for their contributions.

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